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ABSTRACT

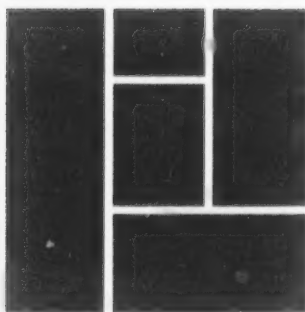
This paper identifies issues and needs related to services for migrant children based on a review of the literature and discussions with experts in the field. Background on migrant children includes definitions; demography; migrant data sources; and descriptions of federal migrant education, migrant health, and migrant Head Start programs. A chapter on the service needs of migrant children focuses on the areas of greatest need in education, social services, and health care. Service delivery issues include gaps in service delivery, possible models for coordination of services, barriers to successful service coordination, and factors facilitating coordination. Features of an ideal program of service coordination are listed. A section on program evaluation and data needs describes key data sources, recommends improvements in data systems, and identifies evaluation issues to be addressed. Appendices contain: (1) a background statement titled "Scope of Work: Services for Migrant Children in the Health, Social Services and Educational Systems"; (2) a 54-item bibliography; and (3) a list of members of the federal working group on health, educational, and social services to migrant children. (KS)

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BACKGROUND PAPER

Service For Migrant Children In The Health, Social Services, And Education Systems



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Project Report

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BACKGROUND PAPER

**Service For Migrant Children In The
Health, Social Services, And Education Systems**

July 22, 1992

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SERVICES FOR MIGRANT CHILDREN IN THE HEALTH, SOCIAL SERVICES AND EDUCATIONAL SYSTEMS

1.0 Introduction and Purpose of the Study

In addition to the many burdens imposed on all children of poverty, migrant children face mobility, language, and cultural barriers. This increases the challenges they face in obtaining educational, health, and social services. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services (DHHS) is concerned with evaluation and policy issues related to services for children and youth. The needs of migrant children are a prime target for studying issues which cut across Federal programs and across traditional categories and professional disciplines.

The timeliness of this study is demonstrated in a number of areas, some specific to migrant farmworkers and some related to the broader issues of service coordination. A recent flurry of new studies released on the subject of migrant farmworkers may be purely coincidental, but we suspect it is indicative of an intensified national interest in this population. Recent studies issued in just the past six months include the Health Resources and Services Administration (HRSA) sponsored study, "Integration and Coordination of Services at Migrant Health Centers (NMRP 1992)," a U.S. General Accounting Office Study, "Hired Farmworkers: Health and Well-Being at Risk (GAO 1992)", and a report of a study conducted for the Administrative Conference of the United States, "Coordination of Migrant and Seasonal Farmworker Service Programs (Martin and Martin 1992)."

Benchmarks such as the 30th anniversary of the Migrant Health Program, the 20th anniversary of the National Health Service Corps (an important source of health professionals serving migrants), and the phasing out of the National Commission on Migrant Education, prompt a "time to take stock" attitude, particularly at the Federal level. Indeed, much has changed since programs such as Migrant Health and Migrant Education were enacted, both in the composition of the migrant population, and in the communities which are served by migrant farmworkers. As our population becomes more multicultural and multiethnic, programs that have been successful in serving migrant farmworkers may be instructive to other service providers and program planners who must learn how to overcome language and cultural barriers.

Beyond the evidence of national interest in the migrant population, this study also fits well into the current focus on children and families and services integration. As stated in an article by Federal officials Martin Gerry and Nicholas Certo, "Within the U.S. Department of Health and Human Services and among the domestic cabinet agencies....a comprehensive service integration initiative is under way. This initiative focuses on strengthening families faced with challenging social, economic, and health problems (in Behrman 1992)." Interest in these issues extends beyond the Federal government. Richard Behrman (1992) notes that "proposals to link health and social services to schools are at the forefront of the policy

agenda for children." He notes that in January 1991, newly elected California Governor Pete Wilson signed an executive order creating a cabinet-level position, Secretary of Child Development and Education, and mandating the presentation of recommendations regarding "the integration of social, health, mental health, and support services in the schools." (Behrman, 1992:6).

The timeliness and relevance of coordination of services for migrant children was recognized by ASPE, which issued a short-term delivery order to address this subject. The objectives of this study are to: (1) identify six exemplary programs for migrant children that are successfully integrating two or more services; (2) identify factors that facilitate integration at the program level, local agency, and community level, and at the state and federal level; (3) identify gaps in services at the sites studied; (4) identify barriers to successful, comprehensive service delivery for migrant children; and (5) identify research and evaluation issues for the future, including evaluation design options, measurement opportunities, and data collection needs.

2.0 Methods and Organization of the Paper

Given the short-term nature of this project, we will attempt to build on existing work as much as possible. For example, a thorough background description (Appendix A) was prepared by the Government Project Officer and was included in the Scope of Work for this delivery order. The main purpose of this paper is to identify issues and provide a structure or "road map" for guiding the project's subsequent tasks. Project staff will be receiving additional materials that have been requested, and will be talking to additional experts in the field over the course of the study. This information will be synthesized and incorporated into subsequent study products as appropriate.

The sources of information for this background paper include a review of the literature and discussions with experts in the field. In addition to the list of references provided by the ASPE Project Officer and bibliographies generated by previous projects on related subjects, a CD-ROM key word search was done of Educational Resource Information Center (ERIC), Popline, and the National Library of Medicine's Health Plan. The key words used were 1) migrant, 2) child and 3) farmworker.

Most of the references found in the search were already referenced in the material we had obtained from ASPE and from prior studies. The ERIC search turned up several new references, mostly related to educational programs and services. The Popline search turned up only two relevant articles that we were not already aware of on the demographic characteristics of migrants, and the Health Plan search turned up a few new references on both health related programs and health statistics of migrants. References cited in this background paper are listed on page 33. A complete bibliography to-date is provided in Appendix B.

In preparing this background paper, meetings or telephone interviews were conducted with individuals knowledgeable about migrant children's service needs, service delivery issues, sources of data and demographic characteristics of migrants and their families. Appendix C provides a preliminary list of the individuals we intend to contact as key informants for this study. As noted, some of these individuals have not yet been interviewed, and some of these contacts resulted in referrals to other individuals. This is a dynamic process which will continue throughout the study in order to refine ideas, obtain suggestions for issues to pursue in site visits, and identify potential site visit locations.

The following chapter briefly describes the migrant population and the main programs that serve migrants. Subsequent chapters describe service needs of migrant children, service delivery issues and evaluation and data needs. Having highlighted key issues in each of these areas, the final chapter summarizes our approach to the remaining study tasks.

3.0 Descriptive Background on Migrant Children

Very little data exists on the demographic characteristics of migrants. The demographic profile differs depending on the way "migrant" and "farmworker" are defined. Additionally, most of the data that exists is biased and/or flawed in some way. This chapter discusses some key definitional concerns, identifies available data sources, and broadly describes the demographic profile of the population. The last part of this chapter describes the major programs that serve migrants.

Definitions

Depending on the definition of migrant farmworker used, this group could have a very different demographic profile, a very different geographic distribution, and would constitute a very different percentage and number of the farmworker population nationally. For example, as characterized by the Department of Agriculture's Hired Farm Worker Force (HFWF) survey, which was based on the agricultural supplement to the December Current Population Survey, farmworkers are mostly white teenagers (Martin and Holt, 1987). In contrast, most program data and the more recent National Agricultural Workers Survey characterize migrant farmworkers as adult, hispanic, male, and foreign-born (Mines, Gabbard and Boccalandro, 1991). This disagreement stems at least partially from a difference in the definition of "migrant farmworker" used, as well as biases in the data.

Generally, for the sake of data collection, migrant farmworkers are defined as persons who cross a prescribed geographic boundary and stay away from their normal residences overnight to perform farmwork for wages. Both the definition of farmwork and the length of stay requirements and distance traveled needed to qualify for migrant status differ among data sources. Some definitions require an overnight stay, some longer. Some require workers to cross county lines, others school district lines. Some farmwork definitions include only crop farming and agricultural services, while others include livestock work, fisheries, packaging, canning, or transporting of agricultural products.

In addition to differences in definition, sources of raw data do not distinguish between migrant and nonmigrant because migrant is not an occupation, but a characteristic of a subgroup of farmworkers. Thus, migrants are estimated as a subset of all farmworkers.

Data Sources and Population Description

The existing employment and wage data is somewhat better than data covering other demographic characteristics of migrants, and has been collected regularly for quite some time. Some of this data is collected quarterly by the United States Department of Agriculture (USDA), and some is collected every five years by the Census of Agriculture.

The data which count or estimate the number and distribution of farmworkers in general, and migrants specifically, vary widely. The estimate for the number of migrant

farmworkers ranges from 115,000 (Slesinger 1984:1) to more than 1.5 million migrants and dependents (Martin and Holt:43a). More recent and more widely accepted estimates place the number somewhere near 600,000 migrants and dependents.

The best data available which provides a demographic profile of farmworkers is the National Agricultural Workers Survey (NAWS). The drawback to this data for our purposes is that it covers all perishable crop farmworkers, neglecting livestock and farm service workers; in addition it does not distinguish between migrants and nonmigrants. There are findings soon to be released which are migrant specific, but they are unavailable as of this writing.

The NAWS data suggest the following profile of agricultural workers providing seasonal agricultural services (SAS):

- Young (65%). Almost two-thirds of SAS workers are under thirty-five years of age.
- Male (71%). Over two-thirds of SAS workers are men.
- Married (64%). Almost two-thirds of SAS workers are married.
- Foreign-born (62%). Almost two-thirds of SAS workers are foreign-born. The majority (51%) of workers have been in the United States longer than eight years.
- Hispanic (71%). Over two-thirds of SAS workers are of Hispanic origin (Mines, Gabbard and Boccalandro 1991:11).

Other social and economic characteristics of this group are: lower than average educational levels, lack of English fluency, low income levels, low level of participation in needs-based social service programs, and a high incidence of supplementing income with nonfarm employment. Almost one-half have eight years of education or less, and fewer than one-half can speak and read English (ibid.:35). One-half of SAS worker families have incomes below the poverty level, yet only 18% are recipients of needs-based social services, the most common of which is food stamps (ibid.:53). Over one-third of SAS workers spend time doing nonfarm work (ibid.:77).

With respect to the numbers of migrant children, 54% of SAS workers have children, almost 80% of whom reside with their farmworker parent at the work site (ibid.:46).

It is estimated that 40% of SAS workers spend some time abroad (this is mainly workers going home to Mexico for some time during the year) (ibid.:83). This 40% estimate is the only proxy for migration currently available, and this only captures farmworkers who

travel from another country, not those who only migrate from state to state or between counties.

Richard Mines, an economist with the U.S. Department of Labor, estimates that one-third of all farmworkers are "shuttle migrants," who go back to Mexico for a month during the year, and 13 to 14 percent are "follow the crop migrants," who work in two or more counties. He also suggested that significant overlap exists between these two groups.

This demographic profile of farmworkers has changed since the inception of many of the federal and local programs which serve them. In the past, farmworkers were more likely to be white, younger and slightly better educated. On the East Coast, migrant farmworkers were more likely to be Blacks who were born in the rural South. Additionally, the proportion of farmworkers who traveled long distances bottomed out during the high gasoline prices of 1979-1980 and has recovered somewhat, but not to the levels of the early 1970's (Martin and Holt 1987:123).

A number of smaller studies provide profiles of migrant farmworker populations in subsections of the country. While these data must be viewed as "snapshots" since they are one-time only studies of specific locales, they do provide additional detail on the demographic characteristics of the migrant population. For example, Dever's study of farmworkers in the midwestern migratory stream, which looked at demographic characteristics in homebase areas in Texas as well as non-homebase areas in Michigan and Indiana (Dever 1991), found that:

- As many as 58 percent of all households in migrant homebase areas in Texas are below nationally defined poverty levels, compared with only 1.4 percent nationally.
- The homebase counties have more children under 15 and fewer elderly over 65 than either the U.S. in general or non-homebase migrant areas.
- Over 20 percent of the households in the homebase area have incomes of under \$7,500; households with incomes under \$7,500 in non-homebase areas range from 7 percent to 14 percent.

Existing Programs

The bulk of services designed to meet the health, education, and social needs of migrant children are funded by a dozen or so Federal programs targeted to migrants and youth. Delivery of these services is further shaped by the specific priorities, resources, and structure of state and local agencies. The primary Federal programs developed expressly for migrants are Migrant Education, Migrant Health, and Migrant Head Start. Each of these programs was established in the 1960s and has its own funding stream and requirements for eligibility. These programs, along with a JTPA program for training youth (Section 402), account for more than \$500 million annually in assistance to migrant and seasonal

farmworkers and their children (Martin and Martin 1992). An additional \$70 million in Federal funds is also available through the following programs: WIC, Migrant Legal Services, Section 514 migrant and seasonal farmworker housing loans and Section 516 housing grants, Community Services Block Grants, migrant vocational rehabilitation, the high-school equivalency program (HEP), the College Assistance Migrant Program (CAMP), and Migrant Even Start. (For an extensive legislative history of federal Programs for migrants, see Martin and Martin 1992). States and localities may also offer a number of social services and supplements to these programs for which many migrants and their dependents are eligible.

Migrant Education. By far the largest of the Federal education programs for the school age migrant population is the Chapter 1 Migrant Education Program (MEP) authorized under the Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 (P.L. 100-297). This program provides grants to state educational agencies (SEAs) to fund programs that meet the special educational needs of children of migratory agricultural workers and fishers and to help coordinate local migrant education projects with similar programs and projects in other States, including the transfer of school records and other information about eligible migratory children. Programs can be provided during the school year, year-round and during the summer. The types of services that may be provided under MEP include both instructional and support services, although the vast majority of services provided are instructional (Marks 1987).

SEAs have considerable freedom in structuring services and deciding which particular services to provide. Allowable activities include: acquisition of equipment and instructional materials; acquisition of books and school library resources; employment of special instructional personnel, school counselors, and other pupil services personnel; employment and training of instructional aids; training of teachers, librarians, and other instructional and pupil services personnel; coordination with similar programs and projects in other states, including the transfer of school records; support services such as health, counseling, food and transportation; parental involvement activities; construction of school facilities, if necessary; and evaluation of MEP projects (U.S. Department of Education 1991).

Grants to states are allocated on the basis of the number of their eligible full-time equivalent migrant children. An SEA may operate a migrant education project directly, or may contract with school districts, or public or nonprofit private agencies for program operations. In general, most migrant services provided through the Chapter 1 MEP program are delivered through SEA subgrants to operating agencies (typically local or regional educational agencies) (Marks 1987). In addition to Chapter 1 monies, the Migrant Education statute provides funding for the collection of data under the Migrant Student Record Transfer System (MSRTS). Originally designed as a way to track migrant students school records from district to district, the MSRTS has also become a means of developing a census count of eligible children (Martin and Martin 1991).

Children are eligible for the special services of Migrant Education under Chapter 1 if they move across school district boundaries because a parent is in search of agricultural employment. In addition to being eligible for the services in a migrating year, these children are eligible for 5 years after the last move as "formerly migrant" children. Migrant Education defines farmwork as crop and livestock agriculture as well as dairy and fishery work. Aside from workers involved directly in farmwork, it also extends benefits to children of parents involved in packaging, processing and transporting in these industries (ibid.).

Estimates of the number of children served nationwide by the Migrant Education Program range from approximately 250,000 to over 350,000. There is some uncertainty concerning these estimates due to the possibility of double-counting when students move to other school districts or enroll in summer school programs. Additional funding is available for tracking migrant students through the Migrant Student Record Transfer System (Martin and Martin 1992).

Migrant Health. Due to widespread agreement that migrants and their families are at greater risk for various health related conditions, Congress has appropriated money for the funding of special health centers to serve the needs of the migrant farmworker population. The bulk of the Migrant Health program money provides funding to the Migrant Health Centers; some also provides funding for special projects with wider impact, such as the National Migrant Resource Program (NMRP), which houses a library of studies and articles relevant to migrant health and sponsors the Migrant Clinicians Network (Martin and Martin 1991).

Migrant Health funds 103 Migrant Health Centers, which operate over 400 clinic sites in 43 states and Puerto Rico. Most of these centers also rely on other state and private sources of funding, Federal public health funding and collection of fees, both patient and third party payments (ibid.). Migrant Health Centers serve about 500,000 migrant and seasonal farmworkers annually--roughly one-six of the estimated three million migrants in this country (Salend and Reynolds 1991; Rust 1990). A 1991 survey of Migrant Health Centers found that the centers either provided directly or coordinated with other agencies to provide a variety of health and social services, either through a formal arrangement or informal referral (NMRP 1992). These services included primary prevention, episodic and chronic medical care, family planning, obstetrics (prenatal and delivery), outreach, transportation, emergency and after-hours care, hospitalization, pharmacy, lab, X-ray, health education, WIC, nutrition education and counseling, emergency food, dental care, and HIV screening, counseling, outreach, and treatment.

The definition used by Migrant Health Centers to determine eligibility includes both migrant and seasonal farmworkers (usually defined as persons performing less than 150 days of farmwork in a year), though priority is to be given to migrants. Any migrants who set up a temporary abode for the purpose of performing farmwork away from their usual place of residence, and their dependents, are eligible for health services and continue to be eligible for

24 months after the last move. Farmworker families may also continue to be eligible for services as seasonal farmworkers long after the 24 month look-back period. Migrant Health defines farmwork as crops only and does not include livestock, though packaging, processing and similar activities are included under some circumstances (Martin and Martin 1991).

Migrant Head Start. Special programs for the children of migrant farmworkers were begun in the early days of Head Start. Thirteen percent of Head Start funding is reserved specifically for the children of migrant farmworkers and American Indians. Unlike typical Head Start centers, which serve only children from ages 3-5, and operate on a half-day basis, Migrant Head Start (MHS) centers are authorized to serve children from birth to five years and often offer full-day programs to cover the entire time that parents are working in the fields. Recently, 35 percent of enrollment in MHS consisted of infants and toddlers. This day care component to Migrant Head Start is often the only source of day care that migrants can afford. Thus, there are often long waiting lists for Migrant Head Start programs (ibid.).

The Migrant Head Start eligibility definition is vague, stating only that the migrant family must have moved in connection with agricultural employment within the last year. Only the production and harvesting of tree and field crops count as agricultural labor and the family's main income must come from these activities. Children of seasonal farmworkers are not eligible for Migrant Head Start.

Migrant Head Start provides Head Start component services--education, nutrition, health, parent involvement, and social services--to approximately 27,000 children (including 9,500 infants and toddlers) in 33 states through 28 grantees and 40 delegate agencies.

4.0 Service Needs of Migrant Children

This chapter describes the areas of greatest need for migrant children in education, social services, and health care. Much of the information is based on descriptions in the literature of the experiences of service providers. We believe it is important to understand the processes used to identify needs. However, the available literature is dominated by descriptions of presenting needs rather than needs identification.

Education Service Needs of Migrant Children

School age migrant children are at a disadvantage due to a variety of factors, not the least of which is their poverty and living situation. Migrant students are frequently language-minority and limited English proficient, maintain cultural values different from those of the majority culture, are residents of rural areas, and live in abject poverty. The families of migrant students are likely to have economic, health, dental and housing needs. While these factors are similar to the disadvantages faced by many at-risk students, the problems are exacerbated by their mobility (IMEC 1987). Families may move several times during a school year as adults search for employment, resulting in irregular school attendance. In addition, students may work in the fields to help support their families (Serrano 1980).

These factors mean that migrant students tend to start school well behind the general school-age population, and continue to fall further and further behind as their lifestyle hinders access to and continuity of appropriate education. The dropout rate among migrant students is apparently quite high (IMEC 1987), as the barriers to school completion become insurmountable. At the secondary level, both interstate and intrastate movement among districts may mean that students become unable to complete the appropriate number of course credits required for high school graduation in any of the districts of attendance. In recognition of these difficulties, there have been some recent efforts to focus more on secondary students to ensure that they can complete diploma programs. For example, in New York state, the Portable Assisted Study Sequence (PASS) program enables students to gain credit through correspondence courses. The state also supports an Adolescent Outreach Program to assist students in transferring credits across schools (Martinage 1986).

For migrant students with disabilities, identification for special education eligibility becomes problematic given the short length of time many students stay in a particular school district. The special education identification and assessment process can be lengthy and costly; it may not be complete by the time a migrant student transfers to another district. At the second district, a timely assessment may also be impossible. Further, the eligibility criteria may differ from the first district. As a result, migrant students with disabilities tend to be identified at later ages than their non-migrant counterparts (California Policy Workshop on the Special Education Needs of Migrant Handicapped Students 1986) and tend to be underidentified among the general population. Yet, the hazards of agricultural work (in particular to pregnant women and young children), limited health, poor sanitation in field and work camp facilities, poor diets, exposure to pesticides, etc., suggests that migrant students

are at particular risk for physical disabilities and learning problems that may affect school success (Reynolds and Salend 1990). A study of migrant children in Washington state (Schneider 1986) found seven to nine percent of migrant children had handicaps requiring special education, compared with 8.2 percent of the total school populations. Lack of knowledge, lack of resources, and cultural beliefs lead to a number of handicapping conditions being unidentified and/or untreated. For example, Schneider reports that many parents believe the defect is "an act of God," or, more commonly, that it is caused by something the mother believes she dreamed, saw or did during pregnancy, or that it is "a cross they must bear." (Schneider 1986). Untreated conditions include deafness, blindness, cerebral palsy, severe retardation, clubfeet, and hip displacements. On the other hand, the Executive Director of Migrant Legal Action notes that sometimes migrant children are placed in special education classes unnecessarily. Special education can be misused as a way to segregate children who are different from the majority population.

Recent studies of migrant students suggest that there have been some changes to the profile of this population that may result in increased school success. Marks (1987), reports that in sites visited for case study, educational interruptions have lessened due to two factors. First, more families are settling-out and establishing permanent residences. Second, children seem to be present for more of the school year, with a number of the students moving only during the summer months. Staff impressions about less frequent movement of students at the sites visited was supported by national data. Less discontinuity of services should lead to increased achievement.

Federal Programs for School-Age Migrant Children

At the Federal level, a number of efforts have been established to target educational services to school-age migrant children, including the Chapter 1 Migrant Education Program, the High School Equivalency Program, the College Assistance Migrant Program, and the Handicapped Migratory Agricultural and Seasonal Farmworkers Vocational Rehabilitation Service Program. In addition, migrant students may participate in the special milk and free and reduced price breakfast and lunch programs operated in the schools and administered by the Department of Agriculture. Migrant Head Start and Migrant Even Start have been established to focus on early childhood programs for migrant students and their families.

For the 1990 calendar year, the Migrant Student Record Transfer System (MSRTS) reported that 433,628 full-time-equivalent students were served under MEP school year and summer school programs. State-reported data indicate that half of the Chapter 1 MEP participants are formerly migrant (Henderson, et al. 1990).

The Chapter 1 regulations state that children who have been determined to be currently migratory are to be given priority over formerly migratory children in the consideration of all programs and activities that other agencies offer. The intent is that the MEP serve students who demonstrate the most need for instructional and support services not already provided by other programs. Need for services is determined by operating agencies

through an annual needs assessment. The needs assessment is to use established educational criteria to select migratory children to participate in the program. One purpose of the needs assessment is to assist operating agencies design and focus the educational component. In addition, the educational criteria must be uniformly applied in selecting students to be served in each grade level and instructional area in which the project will focus (U.S. Department of Education 1991).

Operating agencies appear to have great latitude in defining the criteria to be used in the needs assessment. None of the research studies and other information reviewed provided information on the criteria used by Migrant Education programs to complete their needs assessment, nor are the results of such assessments available. A soon-to-be-released evaluation study of Chapter 1 Migrant Education programs, completed by Research Triangle Institute (RTI) for the U.S. Department of Education, may provide more detail on the identified educational needs of migrant students. That study should also provide illuminating data on the differences in instructional needs and attainment between current and formerly migrant students--a topic of apparent concern to many involved with the migrant education program.

Social Service Needs of Migrant Children

The social and economic profile of the migrant population heretofore discussed suggests that migrant children are in need of public welfare services to meet even the basic needs of food, clothing, and shelter. Nevertheless, few Federal resources in this area are targeted to migrant children and their families. Although migrants are likely eligible for Medicaid, Aid to Families with Dependent Children, and services available through programs such as the Community Services Block Grant, none of these funds are specifically earmarked for services to the migrant population. Their mobility probably makes knowledge and accessibility of such services even more complicated. This lack of targeted funding, coupled with the difficulty in collecting information on the characteristics of the migrant family, makes it difficult to determine the needs of the population in this area. For example, are the needs for alcohol and drug abuse treatment programs among migrants more or less prevalent than in the general population? Would foster care respond to a need of the migrant family?

For school-age migrant children, the Migrant Education program is probably the best source for services that would come under the rubric of social services. As mentioned above, most of the services provided through Migrant Education programs are instructional, but support and supplemental services are also allowable. There is an assumption that the provision of support services will aid in increasing student attendance and attainment. The needs of the population can be gleaned from the types of services provided through MEP.

A relatively recent study completed for the U.S. Department of Education (Rudes and Willette 1990) reported that in the 16 sites visited for case study, all took a holistic approach to serving the needs of migrant children and their families. That is, projects tried to address the ability of the children to participate in and benefit from their schooling. As a result, a

wide range of services were provided, including advocacy, general assistance, and referral for migrant families and students to educational, health care, and social services available in the community; personal and career counseling for students; direct health care services for students; nutrition services; transportation; and coordination with other community organizations and agencies serving migrants.

Marks (1987) also reported that a wide variety of support services were provided to students participating in Migrant Education programs. Although instructional services were paramount, support services provided included guidance and counseling, health screening, medical and dental treatment, transportation, employment, and clothing. Decisions about the exact services to be provided were made locally, on an as-needed basis. The provision of such support services was reported by Rudes and Willette (1990) to be an important component of effective migrant education practices.

Literature in the health field identifies a number of social service and mental health needs of migrant farmworkers. A broad-based needs assessment of migrant farmworkers in Western Oregon (Decker and Knight 1990) found that drug abuse, especially cocaine and crack use, was a rapidly growing problem in this population. Alcohol, drug abuse, and family violence are not uncommon among migrant families (Smith 1986; cited in Decker and Knight 1990). In Western Oregon, most crime in the migrant labor camps was related to drug abuse and prostitution. The workers spend long hours in the fields and most are separated from their homes and families. Leisure activity includes heavy alcohol intake, and alcoholism is a recurrent problem (Decker and Knight 1990). While these problems are more prevalent in the predominantly male migrant labor camps rather than where migrant families reside, the alcohol abuse, sexually transmitted diseases, and interpersonal conflicts affect teenagers and children as well.

A survey of migrant farmworkers in Tulare County, California found that 29 percent suffered from some form of mild psychological distress, and 1.4 percent had serious mental problems (Mines and Kearney 1982; cited in Trotter 1988). A survey of Wisconsin migrants found that four of the ten most commonly mentioned health conditions were: nervousness, irritability, insomnia, and depression (Slesinger 1979; cited in Trotter 1988). However, the Wisconsin study also found that migrants indicated virtually no interest in having access to three types of services: alcoholism services, family planning services, and mental health services. This, despite the fact that one-fifth of migrants were found to be suffering from some type of psychological distress.

The need for social services, particularly mental health and substance abuse services, exists, and appears to be growing. While attitudes may have changed since these surveys were conducted, there still appears to be a substantial need to develop services which are sensitive to those cultural factors that lead to the reluctance of migrants to seek help. There is also a need to educate migrants in the value of such services, and in how to access such services.

Taking a broad view of social services, one must also consider environmental, housing, and child labor issues as important service areas to address because they impact directly on the health, mental health, and educational needs of migrant children. The decision to migrate as a family is often determined by the number of family members who will be able to work upstream, either in the fields or in nearby packing and canning sheds. Since growing seasons are short, the family must maximize the income they can earn, which includes the wages of children above the age of ten or twelve (Trotter 1988). While states have various child labor laws, these are frequently ignored both by migrants and growers (ibid.).

Coordination of environmental and/or housing services with Migrant Education or Migrant Head Start, for example, might prove to be a viable model of service coordination benefiting migrant children. The impact of environmental and housing factors will be discussed in the next section on health needs.

Health Needs of Migrant Children

Migrant children frequently have health needs that go unmet due to fragmented care caused by their mobility, lack of medical and financial resources, substandard living conditions, language barriers, limited health education, and superstitions related to health and well-being. A number of studies have documented the health needs of sample populations of migrants and migrant children, using record reviews, utilization data of Migrant Health centers, and interviews with migrant families and service providers. A study of a representative sample of migrant families in Wisconsin supports the view that migrant farmworkers are at substantially greater risk of health problems and early mortality than the general population (Slesinger et al. 1986). Findings concerning migrant children include:

- Fewer than half of migrant children under age 16 received the recommended annual physical checkup.
- Only one-third of migrant children under age 16 had received an annual dental checkup compared to 50% of children in the total population.
- A rough comparison between levels of chronic health conditions for migrant children and those reported for children in the National Health Interview survey suggest that the incidence of chronic conditions is several times greater among migrant children.
- Childhood mortality appears to be 1.6 times higher than in the U.S. population.

Schneider (1986), reporting on experiences treating migrant families in eastern Washington state, finds that common health problems of migrant children fall into four categories:

1. Diseases and conditions caused by overcrowded and poor living conditions and frequent moves to new climatic areas with different water supplies and native viruses.
2. Nutritionally related conditions.
3. Untreated congenital anomalies, inherited conditions, and allergies.
4. Neglect and lack of adequate medical treatment.

These findings are supported by other studies. Dever (1991) sampled utilization data from four Migrant Health centers in Texas, Michigan, and Indiana, and found that clinic visits for children ages 1-4 are mostly for infectious and nutritional health problems. Health problems for ages 5-9 are also primarily infectious. Viral and bacterial infections, especially upper respiratory infections and gastroenteritis, spread rapidly in crowded migrant camps. They frequently occur when the migrants first arrive in an area where the climatic conditions and water supplies are different from what they are used to. Bacterial diarrheas, such as shigella, can spread rapidly in labor camps and day care centers. Viral Hepatitis A, which occurs often in migrant centers, can be spread to day-care workers through improper handling of dirty diapers. One physician's assistant at a Migrant Health center in Colorado began his coordinated working relationship with a Migrant Head Start program after tracing several cases of diarrhea seen at the health center to the same Head Start site (NMRP 1992).

The incidence of tuberculosis and positive TB skin tests is also high among migrants (Schneider 1986). Trotter (1988) notes that diseases of yesteryear, dominated by infectious diseases, are commonly encountered in the migrant population. In addition to the parasitic diseases and other gastrointestinal infections which abound in the migrant population, other exotic diseases are not uncommon. For example, the majority of the cases of polio encountered in the United States in the past ten years have been found in the migrant farmworker population, with the majority coming from Texas migrants. One migrant health center in South Texas reported 10 cases of yellow fever in a single year (ibid.). Certain groups in the migrant population, such as Haitians and Southeast Asian workers have active cases of diseases that have not been seen in the United States since widespread immunization programs were begun. They may also carry diseases which were common in their homeland but are rare in the United States. The crowded and unsanitary living and working conditions of migrant farmworkers, combined with the mobility of these populations, facilitate the spread of these diseases throughout the migrant population. Toilets and running water are often not available in field work sites, and bacterial contamination of wells at migrant labor camps is a common problem.

Another environmental concern which impacts on the health of migrant children relates to the farmwork environment. Farm labor is one of the top three occupations with the highest rate of occupationally related injuries and illnesses. Occupational hazards include trauma from farm equipment, exposure to the sun, and pesticide exposure. Children are particularly at risk in farm work environments. When they work with their parents in the fields, they are exposed to the same occupational hazards that adults face, but have less experience in avoiding problems, and are more sensitive to the effects of pesticides. Pesticide exposure for pregnant women who work in the fields really affects two children, the infant and the mother, since Mexican and Mexican-American women tend to marry and/or bear children beginning at ages 13 -17 (Decker and Knight 1990).

A study of mothers and children up to age 5 in North Carolina supports Schneider's reporting of nutritionally related conditions in migrant children (Watkins, et al. 1990). 26% of children 1 year and older were found to be at risk for anemia. Infants and children fell below the 5th percentile for height-for-age at more than twice the rate expected. 18-20% of the children were obese. In terms of dietary assessment, only 1/3 of the infants and children received 90% or more of the Recommended Daily Allowance (RDA) for calories. Diets appeared most deficient in the recommended servings in the fruit and vegetable group, and only 1/4 of the children had the recommended three servings from the milk group. Decker and Knight (1990) reported that 18% of the children screened in their study in western Oregon had low hematocrit levels.

Slesinger, et al. (1986) found that 10.9% of migrant children were reported by their mothers as having some type of chronic health condition. The most frequently reported conditions were: trouble breathing, asthma, trouble hearing, heart trouble, and orthopedic conditions. The authors found that migrant families who spoke English were more likely to report that a child had a chronic condition. A possible interpretation is that women who do not speak English may not label various childhood conditions as chronic illness. Thus, chronic conditions may be substantially under-reported among migrant children.

The final category of health problems, those due to neglect, lack of treatment or inadequate treatment, is demonstrated in the areas of immunization status and dental disease. Trotter (1988:43) notes that, "There is probably no other population in the United States that has had simultaneously high incidence of both over-immunization and under-immunization of children. Many pediatric migrant patients have been immunized four or five times in the same season, due to the problems of continuity of care, while others have been missed completely for the same reason." Watkins, et al. (1990) reported that 41% of children served by a North Carolina Migrant Health Center in 1985 were adequately immunized for their ages. In 1986 and 1987, when a program was implemented to provide comprehensive services to mothers and children at this center, more than 60% of children had complete immunizations. In analyzing preventive care for migrant children, Slesinger et al. (1986) found that younger children are more likely to receive checkups, while older children are more likely to receive immunizations. The authors suggest distinguishing between two types of preventive care: one under the direct control of the family, and the other controlled by the

schools. Since immunizations are given to migrant children in schools, the older or school-age children are more likely to be immunized, or even over-immunized.

Schneider (1986) reports that the most common untreated health problem among migrant children is dental caries. Dever (1991) found that dental problems first appear as a presenting condition in children ages 5-9, and that dental disease is the number one health problem for patients aged 10-14. Dental disease is also the number one health problem for males ages 15-19 (for females in this age group the most frequently presenting health condition is pregnancy). "Baby bottle mouth" syndrome, where children's teeth are rotted to the gum line due to the practice of frequently offering sugary liquids in baby bottles, is very common (Schneider 1986; Decker and Knight 1990).

The literature indicates that a comprehensive, culturally sensitive approach is required to met these health needs. Comprehensive health care for migrant families and their children includes:

1. Diagnosis and treatment of common illnesses, infections, and infestations within the family's meager economic means.
2. Referrals for congenital anomalies, chronic conditions, and those conditions requiring additional or specialized health services.
3. The adaptation of teaching programs for the child and his/her parents, including hygiene, immunization status, growth and development, stimulation, nutrition, etc. (Schneider 1986). Migrants have consistently shown interest in further health education, and especially that information which would give them more individual control over their own health (Trotter 1988).

Clearly, the components of comprehensive care discussed above extend beyond the health center setting, and should involve educational, environmental, mental health, as well as many other community resources.

5.0 Service Delivery Issues

This chapter briefly describes gaps in services to migrant children, discusses key issues to be addressed in the coordination of services to migrant children, identifies some promising service delivery models and programs, and outlines characteristics of "ideal" programs.

Gaps in Service Delivery

Despite the availability of Federal funding for services to migrant children, program structures, funding limitations, and lack of service integration have inhibited the delivery of these services and the capacity of agencies to provide all of the services that are needed. The Executive Director of the National Migrant Resource Program notes that, in communities with a sizeable migrant population, there is often a plethora of resources, both in migrant-specific programs and in other programs which recognize migrants as a subgroup to be targeted for services. However, many communities lack the leadership and management skills needed to access and coordinate these resources.

The research literature provides some anecdotal evidence to support the limited capacity of many of the existing programs. For example, Migrant Head Start programs are often in high demand and report long waiting lists for children from eligible families. Because programs operate on a first-come, first-served basis, it is even more difficult for families to enroll their children if they arrive in an area late in the season or are not otherwise knowledgeable about the Head Start program (Martin and Martin 1992).

For a variety of reasons, Migrant Health centers may not have the standard features or provide services that are expected of them: bilingual staff, evening and weekend hours, transportation and outreach support, activities that promote health, and primary and secondary care. For example, in North Carolina, some Migrant Health centers have reduced the number of allied health providers because of cuts in Federal funding and allocation of funds based on provider-patient encounters; and centers give priority to secondary level care rather than promotion and prevention services. This can adversely affect the provision of prenatal and well-child care (Salend and Reynolds 1991). An evaluation study of maternity care in North Carolina's Tri-County Community Health center found limited case finding and follow-up services, and lack of outcome data on patients who delivered infants outside the state (Salend and Reynolds 1991).

A report on Colorado's Migrant Health and Education Partnership found that funding cuts and subsequent reductions in dental hygiene and nursing staff limited dental services, eliminated classroom education on disease prevention and health promotion, and limited coordination and follow-up on health screenings--nurses relied more on Migrant Education staff, and recruiters and records clerks had to restrict their regular duties so that they could provide some services normally completed by the health team (Colorado Migrant Health Education Program 1990). Some communities have migrants in need of services, but have

limited funds or programs in place because the total number of migrants in the area is relatively small.

Service Coordination

To address gaps in services to migrant children, and to address their need for multiple services, agencies have looked to coordination and integration of services for migrant children and their families. The National Migrant Resource Program (1992) identified three basic models for coordination of services:

1. Co-location of services or a "one-stop shopping" model.
2. A contractual model, where one agency is responsible for making sure all needed services are provided and coordinated (this agency may contract with other agencies for services and some services may be co-located).
3. A consortium/collaborative model, in which each agency keeps its own identity but agrees to make cross-referrals, establish procedures for exchanging client information, or share and coordinate the use of support resources.

Several factors have precipitated the need for service coordination. Limited funding and the multiple service needs of many migrant children have motivated service providers to pool their resources to serve common clients more efficiently and holistically. The development of the case management approach also encourages caseworkers to integrate services (most effectively with coordination agreements). Service providers may coordinate through record sharing, common diagnostic and administrative procedures, and cross-training of staff (NMRP 1992).

Barriers to Successful Service Coordination

As one might expect, migrant services share many of the same obstacles faced by programs that serve other disadvantaged populations. The barriers generally fall into three categories: legislative and program requirements, client characteristics, and individual program structure. Conflicting definitions, performance standards, and eligibility criteria of different Federal programs can complicate the process for coordinating outreach and intake (Martin and Martin 1992; NMRP 1992). For example, duplication of questioning by outreach workers is burdensome to migrant families and wastes staff time; and programs may face resistance from parents if children are excluded from some part of a combined program due to eligibility differences.

Agencies must also deal with conflicts over resources and who pays for services; an unwillingness to transfer funds so that more children can be served; and conflicting performance standards across programs. An example of this is Migrant Head Start, which follows more stringent requirements for health screening, and for plans and reports (Martin and Martin 1992). Fiscal provisions for the MEP requiring that Federal funds must

supplement and not supplant funds from nonfederal sources are apparently interpreted by many states as requiring services to be supplementary to all resources, including other Federally sponsored programs. According to Marks (1987), this results in Migrant Education Program funds being considered as the source of last resort. Services provided from all other programs must be exhausted, or deemed inappropriate or inaccessible, before services can be provided through the Migrant Education Program.

Similar provisions in other Federal programs may also provide a barrier to coordination of services, although coordination is a requirement of the Migrant Education program. Another example of a barrier is the difference in eligibility definitions between the Migrant Education program and other Federal programs. MEP allows students to remain eligible for services for at least six years. Most other programs targeted to migrants have a much shorter timeframe. Since migrant education funds can be used for a variety of purposes, this extended eligibility would seem at least to put a burden on migrant education to either prove that MEP students are eligible for services under other programs (such as Migrant Health) or pay for the services through MEP.

The Migrant Student Record Transfer System (MSRTS), which should be a facilitator to coordination, has turned into a barrier as local authorities have begun to treat it as an albatross. As the system becomes more complex and detailed, fewer programs are willing to use it to provide the required information. This brings up another general barrier to coordination--it requires time and resources, which very few programs are willing or able to pay for.

Characteristics and attitudes of migrant families can also inhibit the process for coordinating needed services. In addition to problems associated with mobility, limited English proficiency and poverty, other contributing factors include: cultural and racial differences that alienate migrants from making use of programs designed for them; geographic isolation from services; and the uncertain immigration status of many migrants (NMRP 1992; Salend and Reynolds 1991).

A number of factors related to individual program structure were identified as potential barriers (or facilitators) to coordinating services through Migrant Health centers. These include the age, size, image, and stability of the center; the reputation of the director and key personnel; grower (employer) support; support from the center's board of directors; the skill and stability of staff, especially physicians; the center's commitment to case-managed care; and the amount of discretionary funds available for developmental and organizational efforts (NMRP 1992). A few of the obstacles identified in education include: lack of coordination between funding and service delivery agencies; inadequate demographic data; interstate differences in testing and graduation requirements; inadequate record transfer; and a shortage of trained, qualified personnel to work with migrant children, especially those needing special education (Salend and Reynolds 1991; Gonzalez 1981--abstract).

Factors Facilitating Coordination

As providers of migrant services have sought to overcome the many structural and attitudinal barriers that constrain their ability to deliver services efficiently, they have in recent years cultivated relationships and streamlined procedures to improve their efficiency. Recent reports suggest that service providers are recognizing that coordination and integration of services is advantageous because it improves cost-efficiency, productivity, and patient satisfaction, and decreases provider burnout (NMRP, 1992). Agencies can keep costs low, for example, by dealing directly with health professions, medical, and dental schools to increase staff; or by obtaining small grants or contracts to help develop or expand coordinated service arrangements. State and local agencies for public health, social services, and education can also benefit from contracting or coordinating with Migrant Health centers, and health centers can provide services to more migrants if they are able to obtain partial payment from other agencies (NMRP 1992).

Local agencies have devised other creative ways to coordinate resources and consolidate interagency efforts. To counteract conflicting eligibility and program requirements, providers have utilized waivers and cross-eligibility features. They have also developed consolidated outreach forms to save time and reduce client burden and have organized service fairs with several agencies represented at one site. In many instances, local coordination and coalition building seems to be more important than state-level coordination in bringing about real change in service delivery (Martin and Martin 1992; NMRP 1992).

At the state level, development of statewide task forces or councils, such as Migrant Coordinating Councils and other formal coordinating groups that have a common interest in serving migrants, also appears to be an important contributor to coordinated delivery, especially for new services. "Shared problem identification and joint planning are most likely to lead to coordinated and efficient service delivery" (NMRP 1992:20).

Successful Service Coordination--Features of an Ideal Program

A number of recent studies have documented successful models of coordinated service delivery (see, for example, NMRP 1992; NAEYC 1991). Delivery approaches vary by locality and region, and it is unlikely that any one program will meet all criteria of an "ideal" program at this point in time. However, the literature provides a number of examples of coordination at the state and local level:

- Illinois established a statewide Inter-Agency Committee on Migrant Affairs. The committee meets six to eight times a year to set priorities, identify gaps in services, and examine trends in farmwork (Martin and Martin 1992).
- In North Carolina, a bilingual, multidisciplinary team of health professionals collaborated with a Migrant Health center to deliver primary health care services. This arrangement provided a good example of delivering culturally appropriate services, providing case finding and outreach services, coordinating

maternal and child health services at the local level and across states, and *providing an innovative health education program* (Watkins, et al. 1990).

- Also in North Carolina, the Tri-County Community Health Center provided a variety of services: minor emergency care; screening and physical exams, prenatal and postnatal care, well-child care, pharmacy/laboratory/X-ray services, nutrition and WIC services, dental care, social work, some transportation services, and some translation. The center was part of a pilot study to improve health promotion services for the maternal and child population. Staff included two public health nurses (the project coordinator and health educator), a public health nutritionist, and social worker. Other interesting features of the project included a tracking system to encourage participants to maintain health care and training of migrant farmworker women to be lay health advisors.

The project was considered so effective that the center's administrator created a new position of MCH nurse coordinator, and with more funding hired a bilingual public health nurse and a Spanish-speaking outreach worker. Transportation services were expanded; lay health advisors helped increase consumer participation; and the lay health advisor training program enhanced self-empowerment. As a result of the project, there was an increase in the number of women initiating care early in pregnancy and making more prenatal visits. Many accomplishments were attributed to multidisciplinary team efforts (Salend and Reynolds 1991).

- Indiana's Task Force on Migrant Affairs pools agency funds for intake and outreach; workers at the Department of Human Services and Indiana Health Centers use consolidated intake and outreach forms; financial incentives are given to families to keep and use forms as they get services (e.g., may get discounts or preferred access to a service) (Martin and Martin 1992).
- New York's Mid-Hudson Migrant Education Center offers a Tutorial Outreach Program for more than 700 migrant youth and instruction for parents to help them help their children. The Center also operates a High School Equivalency Program (HEP), and has forged a close relationship with the special education program of State University of New York at New Paltz; collaborated on federal projects to help migrant parents of infants, toddlers, and school-age children with disabilities; and developed a nationwide inservice training program for personnel to work with these parents (Salend and Reynolds 1991:236).
- For the past 20 years, Colorado's Migrant Education and Migrant Health programs have worked together to plan and implement a comprehensive health program for migrant summer school students. Both programs have a contractual agreement to recruit, hire, train, and supervise seasonal health practitioners. Health services include comprehensive health screening of migrant school enrollees, treatment and follow-up of identified health problems,

preventive dental services, and health education. Health education and counseling is geared toward the family and provided at the school site and in migrant family homes. Local school health staff work with Migrant Health staff and other local health providers to provide comprehensive health services (Colorado Migrant Health Program 1990).

- In Iowa, Proteus Employment Opportunities, Inc. provides a wide range of services to migrant and seasonal farmworkers, including employment and training services; primary health care; early childhood education programs; adult education; housing assistance, and a variety of outreach services. The organization receives funding from Migrant Health and private foundations, and is a Head Start grantee.(NAEYC 1991).
- The Rushville Center in New York has a Birth to Five program which provides primary and preventive health care for rural, low income high risk children including those of migrant farm families. The program enhances existing primary care with activities designed to meet the special needs of this high risk population, such as newborn parenting classes, and breastfeeding promotion and support.
- Project Home Base in Yakima, Washington, is an early childhood, preschool program designed for disadvantaged families in the Yakima School District whose children have developmental delays. The central feature of this program is a weekly home teaching visit with the parent and child by the parent educator. The program serves settled out migrants as well as other disadvantaged families in this community.

These examples help to clarify the concept of coordination, but a more rigorous approach is still needed to further develop a common understanding of features that characterize an ideal program. There has been considerable recent interest in the concept of school-linked services. The school-linked services effort is part of a larger movement for more integration of education, health, and social services for children. It is based on the recognition that a number of the noneducational service needs of children and their families are vital to enabling children to pursue their education (Behrman 1992). Integration in migrant services has not traditionally been focused on school-based services, but has evolved in varied ways depending on community resources. Nevertheless, many of the concepts emerging from the school-linked services movement are applicable to meeting the needs of migrant children. Behrman (1992) lists six criteria for school-linked services, which are worth considering in identifying promising models of services coordination for migrant children:

1. Effective efforts require that participating agencies change how they deliver services to children and families and how they work with each other.
2. Planning and implementation should not be dominated by any one institution.

3. Services should be comprehensive and tailored to the needs of individual children and families.
4. Each agency participating should redirect some of its current funding to support the new collaboration.
5. Services should involve and support the parent and the family as a whole.
6. Model programs should be both willing and able to collect data about what is attempted and achieved and at what cost.

These criteria provide a framework for identifying and studying exemplary programs. In attempting to characterize the "ideal" program, the working group serving as advisors to this study agreed that an emphasis on the family as a unit is central to the concept of coordinated care. For purposes of this study, a focus on families with children and youth permits consideration of the entire continuum of service needs by age. For example, the ideal program for families with young children may focus on day care, teaching parenting skills, well-child health care, WIC, and providing transportation to access these services. The ideal program for families of elementary school-age children might combine transition services for children moving from Head Start to elementary school, screening programs to identify children with learning disabilities, immunization programs and provision of record transfers to upstream schools, and dental services. Families with teenage children who either do not attend school or are at risk of dropping out of school might focus on outreach programs in the fields or migrant labor camps, job training and GED programs, HIV prevention education, and mental health services. On an operational level, the working group identified the following components of an ideal program:

- involvement of family
- sharing of information/records
- sharing of staff
- sharing of facilities
- sharing of other resources, such as transportation
- documentation of referral/communication procedures
- documentation of written agreements
- coordinated outreach activities
- employment of a case manager or contact person designated for coordination

- preparation of joint applications for funding
- coordinated scheduling across programs
- coordination of transitions between programs (e.g. Head Start to elementary school)
- existence of an active local interagency council
- evidence of evaluation of coordinated activities and sharing of evaluation information
- documented procedure(s) for assuring continuity when a family moves -- both arrival and departure.

6.0 Evaluation and Data Needs

Evaluation of social programs is always a challenge. This challenge is made more difficult because of the flexibility and variation of coordinated programs. Ideally, each effort is shaped according to the needs and resources of the community, as well as the needs of the individuals served. Thus, by definition, each coordinated service effort differs, both in terms of services offered and administrative structure. In the case of school-linked services, for example, multiagency collaborations offer to coordinate multiple education, health or social services at or near the school site. These efforts usually have several goals that include not only improving student outcomes (such as reduced dropout rates, improved academic performance, and decreased substance abuse), but also family outcomes (such as improved parent-child relationships) and systems outcomes (such as better working relationships among education, health, and social services agencies) (Gomby and Larson, 1992). Due to data limitations, these complexities are even greater for programs serving migrants. All of the standard problems of differing program definitions and data systems, and difficulties in obtaining follow-up data, are intensified when studying migrant farmworkers. The programs involved cross jurisdictional as well as professional boundaries as migrants move between school districts, counties, and states. This chapter identifies and describes key data sources, discusses improvements in data systems that have been recommended, and evaluation issues to be addressed.

Sources of Data

Wage and Employment Data. The Quarterly Agricultural Labor Survey (QALS) is conducted by USDA every quarter for the purpose of tracking farm labor data. QALS is the best source of wage and employment estimates available. It is a survey of 5-10 thousand employers of farmworkers. This survey estimates 1.5 million farmworkers peak season (Mines June 29, 1992).

There are other sources of wage and employment data, namely administrative data such as Unemployment Insurance (UI) data and Workers' Compensation data, but because farmworkers are not universally covered by these programs, the data is often inadequate.

Data on Demographic Characteristics. The Hired Farm Workers Force (HFWF) data was an analysis of the Current Population Survey (CPS) data which is collected in December every other year. The USDA has stopped this survey and relinquished responsibility to the Department of Labor, which has designed their own method of data collection rather than relying on the CPS, which for many reasons is an inadequate source of data on farmworkers. The major inadequacies often cited with respect to the CPS data on farmworkers are 1) December is the month least likely to find farmworkers performing agricultural work; and 2) gathering data on farmworkers, many of whom are migrants or seasonal workers, is very difficult to do from a household survey, because many farmworkers live in temporary housing units and are not covered by the CPS, (ibid.).

The National Agricultural Workers Survey (NAWS) is a targeted farmworker survey, which is an expansion of the HFWF, in response to the Immigration Reform and Control Act (IRCA) of 1986. IRCA charged the secretaries of Agriculture and Labor with annually determining if there is a shortage of workers performing Seasonal Agricultural Services (SAS). Farmworker employers are randomly selected, and then random workers at each site are selected for interviews. The survey is conducted in three six to ten week cycles to ensure seasonal sensitivity. By conducting the interviews at the work site and in cycles, some of the problems noted with the CPS data are avoided, (ibid.).

Program Data. Migrant Education and Migrant Health both collect information on the farmworkers and their family members who receive services. Migrant Health Centers report aggregate patient profile and utilization data under the BCRR system. While these data are often a good source of information on program participants, the main drawback is that only data on migrant and seasonal farmworkers who receive services are collected. Individuals who do not receive health and educational services, but who may fit the definition of migrant farmworker, are not surveyed.

The Migrant Student Record Transfer System (MSRTS) is one source of information used by projects to access data on the needs of students. MSRTS is a national database that stores academic, health, and other education records on migratory children participating in the migrant education program. MSRTS was originally designed to assist in the transfer of required schooling information to those involved in the education of migrant children. The uses of MSRTS have been expanded since its 1969 inception. In 1974 Congress allowed the MSRTS database to be used to estimate the number of migrant children in each state. These statistics continue to be used as the basis for calculating state allocations for MEP funds.

According to a recent study of MSRTS, the record increased in size over its 20 year history, but its utility to local educators actually decreased. As the record became more detailed and the number of students increased, paperwork became a burden and records became less accurate and timely (National Commission on Migrant Education, 1991). Thus, the current ability of the MSRTS to provide complete, timely, and up-to-date information on the needs of migrant students is questionable.

Other Problems with Data. In addition to the problems already mentioned, there are problems common to all data collection with respect to migrant farmworkers. The main problem with standard survey and census data is that there is no distinction made between migrant and nonmigrant. While farmworker is a standard occupational classification, migrant is a characteristic of a subset of these workers. Different methods of estimating the number and distribution of migrants from existing data have been put forth, though no method is unanimously supported. When estimates are made by data that is flawed to begin with, the errors are magnified. Estimates from the most current and reliable data, the NAWS, have yet to be cleared for publication.

The most important issues when considering the data sources to use are:

- Are the data relevant to the group or individuals that are being considered?
- Are migrant and farmworker described in a way that is consistent with the purpose?
- Was the data or analysis sensitive to the fact that migrants are a difficult population to reach?

Recommended Improvements in Data

In their report for the Administrative Conference of the United States, Martin and Martin (1992) recommend the development of a uniform core definition of migrant/seasonal farmworker. They recommend that this core definition be used, initially, for the development of a single, reliable federal census or estimation system, independent of any of the current programs serving migrants/seasonal farmworkers. This core definition requires agreement on a number of parameters: the type of work included; the number of days annually employed in the qualifying type of work; the definition of "migrant;" and the look-back period, (e.g., how long one is considered to be a migrant after a qualifying move). Even if a uniform definition is adopted, collection of data presents unique challenges. Traditional methods of household surveys are likely to miss a large number of migrant farmworkers, and seasonal differences will be significant. Richard Mines suggests that alternative, non-traditional methods, such as worksite interviews, must be utilized to capture information on this hard-to-reach population.

Evaluation Issues

As we learn about some programs that appear to represent "best practices" in coordinating health, education, and social services for migrant children, we will be identifying criteria that identify exemplary programs and indicators of "success." The purpose is not to evaluate those programs included in this study, so much as to use these programs to disseminate approaches that are working, and to identify appropriate indicators that can be used to evaluate such efforts and compare alternative approaches.

Two of the most basic problems in evaluating programs for migrant children are identification of need, and following clients over a period of time. In order to determine whether a program was successful in meeting a need, that need must be identified. Although some work has been done in this area, most needs assessments are both very local (which is not necessarily a problem), and program specific. For example, health needs will be assessed by a Migrant Health grantee and educational needs will be addressed by a local Migrant Education Program or in a State Education Agency's annual report. Localities that take a broad view of the total needs of migrants in their community, and the total resources available to serve them, are the exception rather than the rule. Since the clients as well as the

services overlap for many of these programs, it can be difficult to clearly assess and quantify the needs to be addressed. Without this baseline, evaluation results are on shaky ground.

Transfer of information as the migrant moves is a difficult problem, as indicated in the previous discussion of the MSRTS. Health centers also have standardized record systems, but the systems vary enough to produce some confusion. Most centers provide migrants with copies of their own charts to take along with them or with small health record cards. While many migrants keep those cards for years, some are lost immediately (Trotter, 1988). Some centers send automatic letters to the next most probable locations, although many times a migrant may never get there because plans changed. A pilot study of a family-carried growth and nutrition record for children in North Carolina used a record designed to appeal to parents, and provided education to parents on the use of record. Follow-up was coordinated with counties in Florida, as it was assumed that a majority of migrant families returned yearly to Florida. Among the 29 counties responding to a survey two months after implementation of this record, only 2 counties reported seeing a migrant child with one of the records (Young, et al. 1990). After tracking birth outcomes of pregnant women participating in this project, it became apparent that families traveled to many other states during the winter months.

Without follow-up information, it will be difficult to evaluate an important aspect of coordination, that between programs and localities serving migrants in their home base and upstream. Also, many outcome measures require longitudinal information. Improvements in health status, dropout rates, or academic achievement do not happen overnight. Young et al. (1990) note that collecting reliable follow-up data on migrants requires multistate monitoring and a large sample of participants to compensate for high rates of attrition. Thus, one must be realistic in the selection of outcome variables.

A few process variables lend themselves to quantification, and may be available for evaluation purposes. For example, a comparison of the numbers served and the number of individuals or families eligible or in need of services, if tracked over time, would be a useful indicator of access to such programs as Medicaid, Head Start, and WIC. If these numbers are analyzed along with funding levels over time, a better understanding of the impact of services coordination might emerge. Coordinated efforts are sometimes a response to funding cuts, where "success" means continuing to serve the same proportion of families with more limited resources.

Another evaluation issue inherent in the study of coordinated services is the identification of the unit of analysis. What is a site? The answer to this question is not always obvious. For example, for purposes of this study, a site might be a school with a migrant education program; an IDEA Program (Individuals with Disabilities in Education) grantee; a Migrant Health Center; or a Migrant Head Start agency. In any one of these cases, the "site" identified might have a number of service locations (e.g., at a school, at a day care center, in a mobile van at a migrant labor camp), and different services might be coordinated at each location. A partial list of other programs the site might coordinate with includes:

- Migrant Even Start
- WIC
- School Lunch Program
- Inter/Intra State Coordination Contracts
- Health Education
- Dental Care
- After School Programs
- Outreach to School Dropouts
- Medicaid
- AFDC
- Drug Treatment Program
- Mental Health Center
- Domestic Violence Counseling Agency

In addition to successfully coordinating varying subsets of the services listed above, the sites visited in this study will be selected to represent a range of the following factors:

- Continuity between homebase and upstream, including use of record systems which facilitate continuity
- Age of children served (with particular attention to transition ages, such as between Head Start and Elementary School, elementary school and middle school, etc.)
 - early childhood
 - elementary school
 - youth/dropouts
- Grower involvement/support
- Geographic distribution
 - east coast
 - midwest
 - west coast
- Documentation of formal (written) agreements
- Involvement of non-Federal programs
- Age of program
- Size and complexity of program (dollars, number of users, etc.)
- Locus of program
 - school-based
 - health center
 - early childhood program

-- other

- Coordination between several of the following programs:

- Migrant Health
- Migrant Head Start
- Migrant Education
- WIC
- JTPA
- HEP
- Migrant Even Start

7.0 Summary and Next Steps

The needs of migrant children are substantial and require a broad range of services and clinical skills. This is a short-term study which will visit a limited number of sites. Given the number of ongoing and recently completed studies on migrant programs and coordination of services for migrant farmworkers, it is important that this study focus on areas where additional documentation and research can be of value to service providers, program planners, and policy makers. The focus on children is one unique aspect of this study. Another is the emphasis on local level coordination efforts, as Federal coordination issues have been recently addressed at length (Martin and Martin 1992). Additional ways to focus our approach include:

- Develop criteria for identifying best practices. This will include identifying factors that impede coordination as well as factors that facilitate coordination.
- Use a management approach to present findings. For example, develop methods for managers and policymakers to ask "what resources are out there and how can they be accessed?" Explore organizational mechanisms which facilitate evaluation of needs and resources across programs, with the client/family as the focal point of the assessment.
- Translate what is learned about programs that work so that the knowledge can be used to stimulate other initiatives (technology transfer). The audience for the study's final report will include program managers as well as policymakers.
- Identify areas in need of evaluation and define evaluation questions and indicators to be used in assessing coordinated service efforts. Our on-site discussions will probe for an understanding of how the coordinated program or relationship evolved, how it has changed over time, and what is anticipated for the future.

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APPENDIX A

SCOPE OF WORK
SERVICES FOR MIGRANT CHILDREN
IN THE HEALTH, SOCIAL SERVICES AND EDUCATIONAL SYSTEMS

BACKGROUND

Migrant children may be characterized as the most underserved of the underserved populations in the United States. In addition to the many burdens imposed on all children of poverty, migrant children face mobility, language and cultural barriers. This increases the challenges they face in obtaining educational, health and social services. The average educational level of migrants is eighth grade. Social services that are available to migrant families and children are extremely limited. Agriculture is the only industry that allows for and is somewhat dependent upon child labor.¹

The 1988 poverty line for a family of four in all states except Alaska and Hawaii was \$12,100. The average income for a migrant family of 5.3 in 1988 was \$5,500, nearly \$7,000 below the poverty line for a family of four in the United States.² Weather and crop conditions determine whether there is work; the average number of working days for a migrant worker per year is 150 days.³ Because of the abject poverty in which migrant families live, migrant children are forced to work in the fields to assist their families at a very young age. Migrant children are plagued by the ordinary childhood diseases as well as those brought about by poor living conditions and the circumstances of working in agriculture. In addition to the diseases that children contract generally during childhood, migrant children are exposed to serious environmental hazards from pesticides, motorized machinery and vehicles on a regular basis.⁴ Migrant farmworkers, who are considered the poorest of the working poor today, are engaged in what is now considered the most dangerous occupation in the United States.⁵

It is more difficult for migrant children to receive social, educational and health services because of their unique lifestyle.⁶ Migrant children travel with their families in migrant streams. There are currently three migrant streams; the East Coast Stream, the Midwestern Stream and the West Coast Stream. Most migrants in the East Coast Stream have their homebase in Florida; other homebases are located in different south eastern states and Puerto Rico. This migrant stream moves along the Atlantic Seaboard reaching New York in the fall. The Midwest Migrant Stream has its main homebase in South Texas and flows into the Midwestern states, especially Illinois, Indiana, Michigan, Ohio and Wisconsin. South Texas is the largest homebase area in the nation, and sends migrants to the East Coast and West Coast Streams. The West Coast Stream has its primary homebase in southern California, with other homebase areas

located throughout the Southwest. This stream runs northward into Idaho, Oregon and Washington and other western agricultural states. (Trotter, 1988).⁷ Migrant labor is used in virtually every state. Farms and canning factories are almost totally dependent on migrant labor. Migrants harvest nearly all fruits and vegetables available in the United States.

These families are on the "outside" in the communities in which they live because of the transitory nature of their residence and the linguistic cultural barriers that separate them from the local communities. Migrants usually are of different ethnicity than locals in the areas in which they are working, particularly when they migrate upstream. The children, who are already plagued by language and cultural barriers, are forced to change schools constantly. Health insurance, including Medicaid is virtually non-existent for migrants because of their temporary residential status in the states in which they live. Private health insurance is unaffordable for migrants and virtually never provided by employers.⁸

Housing for migrant families is of extremely poor quality. The facilities in which the migrants live are poorly constructed and overcrowded. Upstream housing is poorer quality, usually, than in the homebase state and the supply is decreasing.⁹

It should be noted that reliable statistical data regarding the migrant population, including their children, is nonexistent. All data systems are seriously flawed for several reasons. Various agencies serve migrants; however the definition of migrant varies from one federal program to another. Collecting reliable information from migrants is made more difficult by the fact that they speak english poorly; are suspicious of outsiders, including government officials; and are difficult to track because of their mobility.¹⁰

One of the data sources sometimes used is the The Migrant Student Record Transfer System (MSRTS). This system, established as a voluntary uniform system for collecting and reporting migrant student information in 1969, was mandated by Congress in 1974. The MSRTS is a state-to-state computer system designed in an attempt to confront some of the problems faced by the mobility of the migrant student by facilitating the transfer of student records. It has subsequently been used to collect other kinds of data on the health status and education of migrant children. In addition, in the early 1970's Congress allowed the Commissioner of Education to use the MSRTS as the source for estimating the number of migrant children. According to the National Commission on Education's 1991 report "Keeping Up With Our Nation's Migrant Students; A Report on the Migrant Student Record Transfer System," this data collection and management system has never been standardized across the states and is used primarily to estimate numbers of children; the MSRTS record has continued to

increase in size but not in refinement. The effect of these problems is a lack of quality of information collected and a lack of data because of refusal to use the system by some educators.¹¹

However, the problems facing migrants have been addressed throughout the literature and small studies have been conducted which reflect recurring themes and highlight some of the barriers facing migrant children and their families in the service delivery system. These issues and barriers are discussed below. In addition, some of the programs developed to benefit migrant children are discussed.

EDUCATION

"A 'currently' migrant child is defined, for federal eligibility purposes as "one whose parent or guardian is a migratory agricultural worker or a migratory fisher and who moved within the past 12 months from one school district to another to enable the child, the child's parent, guardian, or a member of the child's immediate family to obtain temporary or seasonal employment in an agricultural or fishing industry."¹² Of the approximately 350,000 students that are served by the Chapter I--Migrant Education Program; 75% are Hispanic, 12 percent are white (non-Hispanic), 3% are native or Pacific Islanders, 2% are American Indian/Alaska natives, and 4% are of other unspecified race.¹³ Chapter 1 is a federal program which provides funds for the education of all students who are disadvantaged and disabled regardless of migrant status.

Migrant children, as other children of poverty, share the characteristics of low socioeconomic status, limited English proficiency, poor health and high dropout rates. In addition to these challenges, migrant children have the added burden of mobility and the subsequent interruptions in schooling.¹⁴

Migrant children with disabilities present an additional dimension to the significant problems faced in service delivery to migrant children overall. Despite the fact that groups of ethnic and racial minorities are generally overidentified as in need of special education services, migrant children tend to be underidentified and underserved.¹⁵ The major barriers to services for this population include lack of awareness to the needs of migrant students with disabilities and limited communication and information sharing between special educators and migrant education programs.¹⁶ The cultural background and language barriers presented by migrant students present additional, significant barriers and consideration of and sensitivity to need must be part of the process of assessing students to determine the level of disability.¹⁷

To illustrate the under representation of migrant children receiving special education services, a comparison study was conducted in the states of Oregon and California. The results indicated that while federal guidelines indicate that 12% of students from a specific group will be identified as disabled, the number of migrant students receiving special education services in California and Oregon was 1.3% and 3.0% respectively of the total number of migrant children as compared to 8.33% and 10% of the general school population.¹⁸

In a recent report entitled "*Characteristics of Migrant Secondary Youth*", prepared by the BOSCES Genesco Migrant Center under a contract with the U.S. Department of Education, Office of Migrant Programs, several factors were listed as impediments to success for migrant children. These were as follows:

Grade retention and overage factor. These factors are considered among the most significant barriers to success in school. It has been reported anecdotally throughout the literature that migrant students are retained in grades and consequently, are older than their classmates in significantly higher numbers than the general school population.

Family Obligation and Support. Migrant children are likely to view dropping out of school to help their families financially as an obligation.

Mobility. The mobility factor is one of the major issues in the education of migrant children. Migrant students in many instances do not receive credit or even partial credit for coursework they have completed in another school district because credits are not transferred. Curriculum differs from state-to-state. Migrant students are typically seen as outsiders in the schools they attend because of the language and cultural barriers and their limited time in each community.

Tracking. The practice of tracking students according to ability, which has been challenged as a sound educational practice overall, has caused migrant children to be educationally segregated. Migrant students are rarely found in a college-bound course of study and are usually tracked in the lowest ability track in the system.¹⁹

Studies that publish dropout rates for migrant students are thought to be unreliable because the data from the Migrant Student Records Transfer System on which the studies have been based is flawed, as previously explained. However, in 1974 a study conducted by Exotech Systems using data from MSRTS reported a 90% dropout rate for migrant children. In spite of the fact that the study was flawed, it was generally felt throughout the field that this number was realistic. Subsequently, a great deal of attention has been focused on at-risk youth nationally and as

a result, some attempts have been made to improve educational services to migrant children. The U.S. Department of Education, Office of Planning, Budget and Evaluation conducted a study which documented innovative educational programs and analyzed efforts to improve the performance of migrant students in elementary and secondary schools. In the findings of that study several factors were identified that appear to improve the quality of educational programs for migrant children. These factors include coordination with the regular school program and other special programs, parent and community involvement, appropriate instructional materials, methods, approaches and coordination between sending and receiving schools, to name a few.²⁰ However, it is believed graduation rates for migrant students have not improved significantly since the Exotech Systems study.

HEALTH. The data collected on the health status of migrants shares the shortcomings of data collected in the area of education. The data is sparse, incomplete and inconclusive.²¹ In fact, one of the recommendations made in the report *The Occupational Health of Migrant and Seasonal Farmworkers prepared by the United States Farmworker Justice Fund* was the establishment of a standardized health data gathering system.²²

Most recently, however, what has been called the first national study of morbidity in the farmworker population was conducted by Dr. Alan Dever for the Migrant Clinicians Network in partnership with the National Migrant Resource Program. This study was a program health analysis that examined data from 6,969 medical encounters during the study period. Data was collected from two homebase health centers in Texas (where there is a heavy concentration of migrants) as well as two non-homebase health centers in Indiana and Michigan and two control group counties. This study revealed that the migrant population is more at risk for health related problems than the general population; that poverty, malnutrition, infectious and parasitic diseases and poor housing and sanitation have made the migrant population vulnerable to diseases that are equivalent to those in many third world countries (i.e. parasitic diseases and other gastrointestinal disorders) and that the migrant population suffers from health problems that are different than those of the general population in the United States. The Dever study, found that environmental conditions, result in an increase of dermatitis, respiratory and parasitic problems beginning by the ages 5-9.²³

The neglected health needs of migrant children is one of the problems complicating the delivery of educational services.²⁴ Migrants are often excluded from community health services because do not meet eligibility requirements. As a result, they do not receive the care they need to prevent or treat illness.²⁵ As a result, the mobility of migrant students, the factor which exacerbates the problems of receiving adequate educational services, presents significant problems in the

receipt of adequate health services thus reinforcing a vicious cycle. Federally funded Migrant Health Centers, established in 1962 to address the serious needs of this population, are able to serve less than 20% of the migrant farmworkers.²⁶

Some of the unique health-related conditions and risks associated with the conditions under which migrant children live are described below.

Agriculture Child Labor. Agriculture is considered the most dangerous occupation in the United States according to a 1989 National Safety Council publication, *Accident Facts*. In 1980, there were 61 deaths per 100,00 workers.²⁷ Migrant children are exposed to these risks because many are working in the fields at an early age and because the work camps (where they live and play) are in close proximity to the fields. When migrant children work (or play) in the fields with alongside their parents, they are exposed to the same hazards faced by adults. In addition, they have less skill and experience in avoiding these risks.²⁸

In a 1985 national study on the morbidity and mortality due to farm injuries to children and adolescents under nineteen years of age, it is stated that:

Nearly 300 children and adolescents die each year from farm injuries, and 23,500 suffer non-fatal trauma. The fatality rate increases with the age of the child; the rate for 15 to 19 year old boys is double that of young children and 26 fold higher than for girls. More than half (of those injured) die without ever reaching a physician; an additional 19.1 percent die in transit to a hospital, and only 7.4% live long enough to receive in-patient care. The most common form of fatal and non-fatal injury is farm machinery. Tractors accounted for one half of the machinery related deaths, followed by farm wagons, combines, and forklifts.²⁹

Although the incidence of injury and death among migrant children was not specifically documented in this study, one might assume that their exposures to these risks are at least as great as non-migrant children working on farms.

Pesticide-related conditions. In interviews conducted by the Division of Occupational Medicine at Mount Sinai Medical Center in New York in migrant labor camps with forty migrant children, 48 percent reported having worked in the fields with pesticides and 36 percent reported having been sprayed either directly or indirectly with pesticides.³⁰ However, the lack of documented information on the issue was addressed by one of the authors of this study as follows:

Although it is recognized that young workers are exposed occupationally to substances known to be hazardous to adults, including pesticides in agriculture, almost no studies have been done to explore the possibility that young workers may have heightened sensibility to these agents due to metabolic differences and increased body surface area compared to adults. Nor have possible risks in regard to causation of diseases of long latency been explored--a matter of grave concern, given that young workers have many more years of potential exposure. For migrant farmworker children who may spend early years playing in the same fields where they later work, this is a matter of even greater concern.³¹

Poor Water and Sanitation Conditions. The water supply available to migrant workers is typically poor in quality or contaminated. Often there is one water tap for the entire camp and drinking water is not always available. If toilet facilities are available, they are usually overburdened and ineffective. Since solid waste pick-up is not available, it often collects in the living areas and attracts rodents and insects.³² Some of the findings from a chart review survey of four migrant health centers and an urban health clinic of episodes per 1000 patients of sanitation and water-related diseases in Utah migrants and urban poor revealed that diarrhea occurred 20 times as often among migrants as among the urban poor. Nausea and vomiting were 13 times as frequent and gastroenteritis, abdominal or intestinal pain and bloody stool were 6 to 26 times as frequent among the migrant population.³³

SOCIAL SERVICES. "Migrant children do not live in radically different circumstances than they did fifteen years ago before there were federal programs....Families still live in abject poverty, crowded, at best into airless concrete block structures, reminiscent of refugee camps....While specially targeted services have become increasingly available, public welfare services, in general, remain equally inaccessible as before. Migrant families lack even the most essential elements of survival; food, clothing and shelter. Medicaid, Aid to Families of Dependent Children and other programs such as foster care, protective services remain beyond their reach."³⁴ The mobility of the migrant family complicates the delivery of social services. Because the families reside in many different communities for short periods of time, their knowledge about the availability of services is restricted. Transportation, language barriers, community attitudes and the administrative burdens on the social service agencies further complicate accessibility. In addition, social service agencies are most often located in urban areas and are typically oriented towards the needs of urban residents. As a result, migrants are the last group to receive social services.³⁵

FINANCING. As mentioned earlier, eligibility for federal programs differs from state to state. As a result, migrants can be denied services either because of the failure to meet residency requirements or differing criteria in their various residences. Migrant populations face the same obstacles as other poor people in that categorical programs and funding streams can impede the receipt of services and benefits. In addition, migrant programs are segregated even within the categorical programs. Some sources of funding specifically for migrant children programs, however, do exist and are described below.

The Migrant Health Act, enacted in September 1962, added Section 310 to the Public Health Service Act to provide comprehensive primary health care to migrant and seasonal farmworkers in Migrant Health Centers. The appropriation level for 1991 exceeded \$51 million. About 65% of the centers also receive funds from the Community Health Center program authorized under Section 330, Public Health Service Act. Migrant Health Centers are run by the Public Health Service in the U.S. Department of Health and Human Services. There are currently 122 migrant health centers operating 378 clinics in over 300 rural areas and Puerto Rico. 1991 statistics from the Public Health Service, Health Resources and Services Administration, Bureau of Health Care and Delivery Assistance in 1991 reveal that the Centers serve about 450,000 migrant and seasonal farmworkers representing about 20% of that population.

Migrant Head Start was established to provide comprehensive early childhood programs for migrant children. It is administered by the Administration for Children and Families, U.S. Department of Health and Human Services. Currently, there are 27 migrant Head Start grantees and 35 delegate agencies in 36 states serving approximately 24,000 migrant children. The funding level for 1991 was about \$60 million.

State Basic Grant Program. This program, administered by the U.S. Department of Education, provides funds to state educational agencies (SEA's) to implement instruction and support programs for migrant school-aged children. The total federal funds appropriate for FY 1990 exceeded \$274 million. In addition, migrant children with disabilities are entitled to receive services under the Individuals with Disabilities in Education Act (IDEA). The discretionary grant program under IDEA has provided grants for programs that have directly benefitted migrant children with disabilities.

Migrant Even Start. This program provides funds to establish and improve programs to meet the special educational needs of migrant children by integrating early childhood education and adult education for their parents into a unified program. The program is administered by State Educational

Agencies and the appropriation level for FY1991 was nearly \$1.5 million.

Special Supplemental Food Program for Women, Infants and Children. (WIC). The WIC program funds special nutritious supplemental foods and nutrition education, including information about the dangers of alcohol and other drug use during pregnancy, to low income pregnant, postpartum and breastfeeding women infants and children up to age five, who are determined to be nutritionally at risk. This legislation provides for a special migrant set-aside of not less than nine-tenths of one percent (.9%) which amounted to \$16.2 million in 1991. This program is administered by the Department of Agriculture at the national level and state and local agencies overseeing 8300 service sites.

National School Lunch Program, Special Milk Program, School Breakfast Programs. These programs, administered by the Department of Agriculture, provide subsidized meals and milk in schools that choose to participate. Children must meet eligibility requirements and would be available to qualifying migrant children.

Inter/Intrastate Coordination Contracts. This program is administered by the U.S. Department of Education. **Inter/Intrastate Coordination Contracts** are intended to improve coordination of education and support services for migrant children nationwide. **Migrant Student Record Transfer System** is a contract that provides for a computerized system that transfers academic and health data on migrant children as they move between state and local education agencies. The total funding appropriated for FY1990 was \$8.1 million.³⁶

Research and Studies

A number of studies of the migrant population are now being conducted. They include a study recently completed by the General Accounting Office at the request of the Chairs of the Select Committee on Aging, Children, Youth and Families and the Committee on Education and Labor to study problems facing migrant farmworkers including housing, health care, labor standards, Social Security, pesticides, child labor and education to determine how federal laws and programs affect farmworkers.

In addition, a study is being conducted by the Administrative Conference of the United States under contract from the National Commission on Migrant Education to document legislative and regulatory barriers to the delivery of services to migrants. This study will result in a set of recommendations dealing with the integration of the Job Training Partnership Act (JTPA), Head Start, Migrant Health and Chapter I-Migrant Education.

The Head Start Bureau plans to conduct a descriptive study to document the "homestate " and "upstream" migration patterns of families served by the Head Start program and to arrive at estimates of migrant families in need of services.

The Migrant Health Program of the Public Health Service is currently conducting a study under contract with the National Migrant Referral Project. This case study will identify innovative Migrant Health Centers that have provided other services for migrant families. Nine sites will be documented for this study.

The study currently proposed will document the current "best practices" in the comprehensive coordination and integration of educational, health and social services; and identify gaps and barriers within current service systems.

OBJECTIVES

1. To identify 4-6 programs for migrant children that are successfully integrating two or more services. The two services should be a combination of education/health, education/social services, health/social services. This would not include two services that are traditionally characterized as social services such as day care and foster care. At least two of these programs should be coordinating with each other in a homebase and upstream site. These programs should be serving children who are identified as "currently migrant" by the U.S. Department of Education definition.
2. To identify the components of these programs that lead to successful integration of education, health and social services for migrant children including interagency agreements, the existence of interagency coordinating committees, the intensity of the efforts at the local level including involvement of the local community, and efforts at the state and federal level.
3. To describe the gaps in services in these sites.
4. To identify barriers to successful, comprehensive service delivery for migrant children through conversations with those involved in administering programs at the local and state level.
5. To identify possible areas for future research and evaluation studies, This objective includes development of an evaluation design options and the identification of measurement opportunities and data collection possibilities.

A P P E N D I X B

Appendix B

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A P P E N D I X C

APPENDIX C

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no

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